

Glare/Light Sensitivity			
Eye Pain or Soreness			
Infection of Eye or Lid (Blepharitis, Stye)			
Tired Eyes			
Crossed Eyes, Lazy Eye			
Drooping			

	YES	NO	EXPLANATION OF PROBLEM
GENERAL/ CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, Ear Infection, Chronic Cough, etc.)			
CARDIOVASCULAR (Heart, Vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, etc.)			
GASTROINTESTINAL (Stomach, Ulcers, Intestinal Disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLE, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, Warts, Skin Cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc.)			
PSYCHIATRIC (Anxiety, Depression, etc.)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
BLOOD/LYMPH (Anemia, etc.)			
ALLERGIC/ IMMUNOLOGIC (Hay Fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY M=MOTHER, F=FATHER, S= SIBLING, GP=GRANDPARENT

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart Disease or High Blood Pressure			
Stroke			

SOCIAL HISTORY

- Do you drive? YES NO
- Do you have visual difficulty when driving? YES NO
- Do you have problems with night vision? YES NO
- Do you drink alcohol? YES NO _____
- Do you use tobacco products? YES NO _____
- Have you ever had a blood transfusion? YES NO
- History reviewed. No changes Additions as noted above.

DOCTOR'S SIGNATURE: _____ **DATE:** _____